Group Short Term Disability

Maricopa County

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Plan Outline

Description of eligible classes

All regular status employees engaged in active employment who are scheduled to work 50% full time.

Amount of coverage

The amount of coverage (%) is elected by you at the time you enroll for coverage in the Short Term Disability Benefits Plan. You may select one of the following Benefit levels:

- 40% of basic bi-weekly earnings to a maximum benefit of $2000.00 bi-weekly.
- 50% of basic bi-weekly earnings to a maximum benefit of $2000.00 bi-weekly.
- 60% of basic bi-weekly earnings to a maximum benefit of $2000.00 bi-weekly.

You may increase your coverage only during a regularly scheduled open enrollment.

You may decrease your level of coverage or cancel coverage at any time.

Maximum Benefit Period

Benefits shall continue up to a maximum of 5 months from completion of the elimination period.

Elimination Period or Benefit Waiting Period

30 consecutive days.

Minimum Requirement for Active Employment

All regular status employees engaged in active employment who are scheduled to work 50% full time.

Definition of Basic Earnings

"Basic bi-weekly earnings" means the amount of regular weekly salary or wages paid by your employer. This does not include commissions, bonuses, overtime, incentive pay, shift differential pay, any other extra compensation or any cash in lieu of benefits.

Enrollment Waiting Period

If you are eligible for coverage as outlined on the previous page, you must first request coverage on a form, which is satisfactory to the County, and agree to make premium payments.

- Coverage begins for new hires on the first pay period following 14 days after your enrollment election is received by the Benefits Division -- Please refer to "MariPlan, Benefit Plan Highlights" booklet.

- Coverage for eligible employees enrolling during open enrollment will become effective the scheduled effective date of the new plan year.

Exception to When Coverage Becomes Effective

If you are not actively at work on the date you would otherwise become covered under this STD plan, your coverage will be delayed. Your coverage will become effective after you have been actively at work for thirty days. If your effective date falls on a weekend, holiday or any day that is not a scheduled work day, you will be covered if:

- You were actively at work on your last scheduled workday, and
- You were able to perform your occupation, had the effective date been a regularly scheduled workday.

If you do not elect STD coverage within 31 days after the date you become eligible for coverage, you will not be eligible to elect coverage until the next open enrollment.

Contributions

The cost (called "premium") of this coverage is paid entirely by you through payroll deductions. The total cost of your coverage under this Plan depends on the bi-weekly benefit level you choose.

Terms You Should Know

Many terms used in this booklet have special meanings. A list of these terms and their meanings follows:

- "Active Employment" means you must be currently working:

1. For your employer on a 50% full time basis, regular status and paid regular earnings:

2. At least the minimum number of hours shown in the plan outline; and either

3. At your employer's usual place of business or

4. At a location to which your employer's business requires you to travel.

- "Basic Bi-Weekly Earnings" - as defined in the Plan Outline.

- "Disability" and "Disabled" means that because of illness or injury you cannot perform each of the material duties of your occupation.

Furthermore, you are not considered disabled or under a disability unless you are under the regular care and treatment of a licensed physician, who is practicing within the scope of his/her license during the entire period of disability.

- "Disability Benefits" means money that is paid as a bi-weekly benefit when your claim has been approved.

- "Elimination Period" means a period of consecutive days of disability for which no Short-Term Disability benefit is payable. The elimination period is shown in the Plan Outline and begins on the first day disability.

- "Employer" means Maricopa County and includes any division, subsidiary, or affiliated company named in the Plan.

- "Gross Bi-Weekly Benefit" means the disability benefit amount before any reduction for other income benefits and earnings.

- "Illness" means sickness, disease, or other medical conditions including pregnancy. The disability resulting from the illness must begin while you are covered under the plan.

- "Complications of pregnancy" means that part of the pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management.

A complication may exist:

- during the pregnancy
- during the delivery
- after the delivery

But complications of pregnancy do not include an elective cesarean section.

"Injury" means bodily injury resulting directly from an accident and independently of all other causes. The disability resulting from the injury must begin while you are covered under the Plan.

- "Net Bi-Weekly Benefit" means the disability benefit amount after any reduction for other income benefits and earnings.

- "Physician" means a person (other than you, your spouse, child, brother, sister or parent, or parent of your spouse) who is:

1. Operating within the scope of his/her license; and either

2. Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or

3. Legally qualified as a medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statues or the insurance regulations of the governing jurisdiction.

- "You" and "Your" means you, the employee.

Disability

When do disability benefits become payable?

The claim administrator approves payment of a bi-weekly benefit after the end of the limitation period and only when you and your doctor provide proof that you:

1. Are disabled due to illness or injury, and

2. Are under appropriate treatment and care of a physician.

What conditions must be met for benefit payments to continue?

You will be paid a bi-weekly benefit as long as you remain disabled and are under the appropriate treatment and care of a physician. You will not be paid longer than the maximum benefit period shown in the Plan Outline.

The claims administrator may require that you be examined, at your company's expense, by an independent physician specialist. If you fail to comply with such a request, the result may be an interruption in or suspension of benefits. Benefits may also be suspended if the results of the independent examination determine that you are not disabled under the definition of the Plan.

You will be required to file a claim with the claims administrator in order to be considered for benefits. You will also be required to give the claims administrator periodic proof that your disability continues. Such proof will be provided at your own expense.

How is the benefit figured?

To figure the amount of your bi-weekly benefit, take the percent (%) of your basic bi-weekly earnings that you selected and deduct any 'Other Income Benefits' you are receiving that offset your benefit from this plan. Benefits payable for less than one bi-weekly period will be paid to you at the rate of 1/14th of the short term disability benefit amount for each day of total disability.

What are "Other Income Benefits"?

1. Applicable amounts provided under any Workers' Compensation law (including pay continuation program)

    a. Modified Duty
    b. Buyback program

2. Any amount provided under federal maritime law

3. Any amount you are entitled to, under any group insurance plan of your employer, that provides disability income benefits

4. Any benefits you are entitled to receive under the provisions of any retirement or pension plan, regardless of whether your employer sponsored or maintained the plan beginning for disabilities commencing on or after January 1, 1996.

5. Any benefits you are entitled to receive under the No Fault Insurance award or through Third Party Subrogation beginning for disabilities commencing on or after January 1, 1996.

6. Any benefits you or your dependents are eligible to receive because of your disability or age under the United States Social Security Act or similar plan or act. If benefits from these programs are denied for any reason (except your non-insured status), you will be required to appeal the denial to the full extent permitted. You will continue to be considered eligible to receive these benefits until all appeal processes are exhausted.

7. Any benefits you are eligible to receive under any plan or provision providing period payments for disability, or providing benefits for loss of time or income, to which your employer, union, trade, or professional organization directly or indirectly sponsored or contributed;

8. Any benefit payable under any state compulsory benefit act or law

9. Any benefits available from any Salary Continuation Plan, including but not limited to Income protection, sick leave, donated leave, etc.

What if I receive a lump sum payment from these other income sources?

The claim administrator will prorate lump sum income benefits on a bi-weekly basis over the time period for which the sum is given. If no time period is given, the lump sum amount will be prorated over your expected lifetime, as determined by the claims administrator.

When do these benefits stop?

Benefits will stop on the earliest of:

1. The date you are determined to be no longer disabled;
2. The end of the Plan's maximum benefit period; or
3. The date of your death.
4. However, if you are disabled on or before the date your coverage terminates and would otherwise be entitled to benefits for that disability, benefits will be payable as though coverage had not terminated. Benefits under this extension will be payable only if the disability continues without interruption.

What happens if I return to work and become disabled again?

If you are disabled, return to work, and become disabled again due to the same or related cause, the second disability will be considered a continuation of the first period of disability, as long as you had returned to work for less than 14 consecutive calendar days.

If your second disability is unrelated to the first, or if you have returned to work for more than 14 consecutive calendar days, the second period of disability will be considered a separate claim and a new Elimination Period must be satisfied before benefits will become payable.

General Exclusions

What Disabilities aren't covered?

This plan will not provide any disability benefits if:

1. You are not under the direct care of a licensed physician;
2. You are engaged in any work for remuneration of profit;
3. You injure yourself intentionally or attempt suicide, while sane or insane;
4. You participate in a felony or become disabled as a result of such participation;
5. You are confined in any penal or correctional institution as a result of a conviction for a criminal or other public offense;
6. Your disability is the result of a war or act of war, unless you are a united states expatriate or on temporary assignment in a war area on employer business, or while you are in the military service of any country which is at war;
7. Your injuries are sustained while you are on a personal leave of absence without pay, excluding jury duty and vacations (see also "Active employment" in Terms You Should Know, above; beginning January 1,1996.
8. You have a vague or undefined condition (such as "tiredness" or "pain"), for which your doctor cannot provide a medical diagnosis;
9. You have cosmetic surgery, except surgery made necessary by accidental injury incurred while covered under the Plan;
10. You have an injury, sickness or pregnancy for which you receive medical treatment within the three months before the date of your coverage under the Short Term Disability Program. This exception does not apply to disable commencing after a Plan Participant has been covered under the Plan for a period of twelve continuous months.

"Received medical treatment," means that you have consulted with or received the advice of a licensed medical or dental practitioner, including advice given during a routine examination. It also includes situations in which you have received medical or dental care, treatment or services including taking drugs, medication, insulin or similar substances.

Termination

When does coverage terminate?

You will cease to be covered on the earliest of the following dates:

1. The Date your employer discontinues the Plan;
2. The date your employment with the company ends;
3. The date you retire under any normal retirement plan or your employer's retirement plan;
4. The date you cease to be an eligible employee;
5. The date of your death;
6. The last day of the coverage period for which premium was paid;
7. If you are disabled on or before the date your coverage terminates and would otherwise be entitled to benefits for that disability, benefits will be payable as though coverage had not terminated. Benefits under this extension will be payable only if the disability continues without interruption.

Some General Information to Know

When must you submit a claim?

You must give the claims administrator proof of claim no later than 30 days after your disability starts. If that is not possible, you must notify the claims administrator as soon as you can.

You must give the claims administrator proof of continued disability and regular treatment by a physician within two weeks of the date the claims administrator requests such proof.

When are claims paid?

When the claims administrator receives satisfactory proof of claim and your claim for disability benefits is approved, benefits payable under the Plan will be paid bi-weekly during any period that you remain disabled under the terms of the Plan.

What constitutes proof of claim?

In order for a claim to be processed, the claim administrator must receive your application for benefits, as well as sufficient medical evidence in support of your claim. Such evidence may consist of records from your doctor, narrative reports, x-rays and any other medical records, as well as evidence that you continue to be under the appropriate care and treatment of a physician. In the absence of such proof, the claims administrator may elect to suspend benefits until such proof is received.

Your disability must be supported by current medical evidence. You must be under the continuous care of a qualified physician, with a course of treatment that is appropriate for your condition.

If you doctor cannot substantiate your disability by objective findings, you may be required to see a doctor selected by the claims administrator for an independent evaluation. Failure to cooperate with such requests may result in an interruption in benefits.

To whom are benefits paid?

The claims administrator will advise you of their decision within 60 days of receipt of your claim for disability benefits. In the event your claim is denied, you will receive a written notice from the claims administrator which must include:

1. The specific reason or reasons for the denial, with reference to those plan provisions on which the denial is based;

2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and

3. An explanation of the steps to be taken if you or your beneficiary wish to have the decision reviewed.

Please note that if the claims administrator does not respond to your claim within the time limits set forth above, you should automatically assume that your claim has been denied and you should begin the appeal process at that time.

What do you do to appeal?

You, the claimant, or your authorized representative may appeal a denied claim within 60 days after you receive the claims administrator's notice of denial. You have the right to:

1. Submit a written request for review to the Claim administrator;
2. Review pertinent documents; and
3. Submit issues and comments, in writing, to the Plan Administrator.

The Claim Administrator will make a full and fair review of the claim and may require additional documents, as it deems necessary or desirable in making such a review. A final decision on the review shall be made no later than 60 days following the Claim Administrator's receipt of your written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision shall be made no later than 120 days following receipt of your request for review. The final decision on review shall be furnished in writing and shall include the reasons for the decision with reverence, again, to those Plan provisions upon which the final decision is based.

Name of the Plan:
Maricopa County Short-Term Disability Plan

Group Number
10491

Name and Address of Employer:
Maricopa County Human Resources
Employee Benefits - Administration Building 2nd Floor
301 West Jefferson Avenue
Phoenix, Arizona 85003-2145

Who pays for the plan?
The cost of this plan is paid entirely by you.

Plan Administrator:
Maricopa County Human Resources/ Employee Benefits
301 West Jefferson Avenue
Phoenix, AZ 85003-2145

Agent for Service of Legal Process:
Plan Administrator as stated above.

Claims Administrator:
Unum America
227 West Monroe Street, No 2700
Chicago, IL 60606
1-800-345-6495